Kansas Department of Health and Environment

Long Term Care Program

FACT SHEET

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In this issue….

The *Fact Sheet* is published by the Kansas Department of Health and Environment.

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☞PLEASE ROUTE THIS *Fact Sheet* TO NURSING STAFF AND OTHER INTERESTED PARTIES IN YOUR FACILITY. THIS PUBLICATION MAY BE COPIED OR ACCESSED THROUGH THE INTERNET ADDRESS ABOVE.

The Long Term Care Program Fact Sheet is a newsletter published by the Kansas Department of Health and Environment and sent quarterly to all nursing facilities, long term care units in hospitals, critical access hospitals, intermediate care facilities for the mentally retarded and nursing facilities for mental health. This newsletter provides important up-to-date information concerning the nursing facility industry.

Change in Bed Capacity or Location of Medicare/Medicaid Units

In a recent State Operation Manual (SOM) revision, the Kansas Department of Health and Environment (KDHE) was advised by the Health Care Financing Administration (HCFA) of a change that takes place immediately regarding the change requests from providers in Medicare/Medicaid facilities.

Medicare/Medicaid participating facilities may elect to **change the number of beds** that are certified to participate in the Medicare or Medicaid program up to **two times per cost reporting year** in accordance with the requirements set out in the May 2000 State Operations Manual (SOM), Revision 16. In other words an institution or institutional complex may only change the bed size of its SNF and/or its NF once on the first day of the beginning of its cost reporting year and again on the first of a single cost reporting quarter within that same cost reporting year in order to effect a change. **At no time** can the KDHE **approve two decreases** in the bed capacity of a nursing facility within the same cost reporting year.

Essentially, the SOM indicates an institution or institutional complex seeking a change in the number of Medicare and/or Medicaid certified beds must:

- ❑ **submit a written request** to the Kansas Department of Health and Environment (KDHE) for the change 45 days before

  - the first day of its cost reporting year to effect a change on the first day of its cost reporting year or;

  - the first day of a single cost reporting quarter within the same cost reporting year at which time it seeks to change its bed size to effect a change on the first day of the designated cost reporting quarter; and

- ❑ **submit floor plans** identifying all areas of the institution or institutional complex with the current certified bed configuration and the proposed certified bed configuration in order for KDHE to determine that the proposed change is in fact, in conformance with the rules for the participation or distinct part certification, which ever applies; and

- ❑ include a **reference to the cost reporting month** the institution or institutional complex.

KDHE will review providers' request and notify them in writing of our determination regarding the request, including the effective date of the change in bed capacity and the bed locations, prior to the start of the cost reporting year or the cost reporting quarter, whichever applies.

In Medicaid, in which every bed is also Medicare certified, the policy was implemented July 1. The policy will be implemented for Medicaid facilities and Medicaid facilities with distinct part Medicare units on November 15, 2000. The last opportunity for these facilities to change their bed capacity on a monthly basis will be October 29, 2000. Any requests dated after October 29 will be approved or disapproved based on the SOM directives.

To assist facilities in requesting changes in resident capacity or an increase or decrease in the number of Medicare certified beds, the bureau has developed one form to facilitate this process. After October 1, 2000, the bureau will only honor requests submitted on the appropriate form. The form to be used to request the above change is attached to this notice. It is recommended that facilities make copies of the forms and keep the originals in a safe place. A copy of the form to be used is attached to this *Fact Sheet*. **Note:** Kansas Administrative Regulations require all licensed beds in nursing facilities participating in the Medicaid program be certified.

Please direct your inquiries and requests you may have regarding bed changes to Charles Moore, Certification Coordinator at 785-296-1263.

Changes in the State Mandated MDS Form

The State of Kansas received permission from the Health Care Financing Administration to change the Minimum Data Set for Kansas Medicare/Medicaid certified nursing facilities. The changes will be effective October 1, 2000. A notice was sent to all software vendors concerning the changes in the Kansas instrument. Please contact the facility's software vendor if an update has not been received for the October 1, 2000 changes. Please note that the Health Care Financing Administration required a change in the instrument effective September 1, 2000. The HCFA change inserts the attestation language at Sections AA and AT5. Therefore, Kansas Medicare/Medicaid nursing facilities will receive an update for September 1 changes and another one for the October 1 changes. Please contact your software vendor if you have any questions concerning the changes in the software.

The following are the changes in the Kansas instrument effective October 1, 2000.

1. A full MDS assessment will no longer be required for the quarterly assessment. The RUGs III 1997 quarterly assessment will be the Kansas requirement for quarterly assessments. The new quarterly assessment is three pages in length.

2. Kansas will continue to require Section U. Medications -Case Mix Demo form to be completed for **initial assessments**, **significant change in status assessments, significant correction of prior full assessments, and annual assessments.** Section U will not be required for quarterly assessments. Your software should be designed to allow you to leave Section U blank on quarterly assessments.

3. Section T. Supplement-Case Mix Demo will continue to be used with each assessment. If Section T was eliminated, facilities would not have the Medicaid case mix group information. Section T is **required for Medicare assessments.** When completing assessments and **Medicare is not the source of payment**, facilities may choose to do the following:

   A. Place dashes in the boxes for days and minutes of recreation therapy for Section T.1.a.

   B. Skip Section T.1. b., c., d. (Ordered therapies) and Section T. 2.a. through e. (walking when most sufficient).

4. Section S will be deleted from the Kansas instrument. Therefore, after October 1, 2000 Medicare/Medicaid facilities will be not required to complete Section S.

The HCFA system will accept a full assessment coded as a quarterly after October 1. However, the system will only store those items included on the three page quarterly form.

Licensed only nursing facilities licensed under the Adult Care Home Act will continue to use the MDS from Section A through Section R and the three page quarterly review form. Licensed only nursing facilities are not required to transmit MDS assessments to the state repository.

Change in Reasons for Assessments

After October 1, facilities which use the three page quarterly must code reasons for assessment as 5 at Section AA.8.a. If there is a need to submit a significant correction of a quarterly three page assessment, code Section AA.8.a. as 10.

It is very important that this information is shared with all staff who have responsibility for performing and encoding the MDS. If you have any questions please contact Anita Gardner Hodge at 785-296-4222.

Keeping Up to Date on the Resident Assessment Instrument

The Bureau of Health Facilities provides current information concerning the RAI process by posting information on the MDS Welcome Page. The MDS Welcome Page is maintained by staff at Myers and Stauffer, LC. Whenever a facility staff person transmits MDS assessments to the state data base, the first screen in the MDS submission system is the welcome page. This page includes the latest update of information from the Health Care Financing Administration and from the MDS Educator, Anita Hodge. Each facility should develop and implement a procedure which ensures that someone from the facility is responsible for checking the bulletins on this site at least once a week. The bulletins should be printed or downloaded to a file for future reference. The Health Care Financing Administration website is reviewed daily for new information. RAI information is posted to the MDS Welcome Page as soon as possible.

RAI Questions and Answers

Q. If a resident receives a small or large portion of a regular diet, is this coded as a therapeutic diet?
A. No, the diet is considered to be regular diet.

Q. May a certified dietary manager complete the Nutrition Resident Assessment Protocol?
A. No. A licensed nurse or registered dietitian must complete the RAP. The RAP process includes assessments which cannot be delegated to a dietary manager by a registered nurse or a dietitian.

Q. Is an initial care plan required for new residents prior to the completion of the comprehensive care plan.
A. Yes. This issue is discussed in the **Long Term Care Resident Assessment Instrument Manual** on page 5-7. "Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status." An initial care plan must address issues related to nutrition, risk for falls and/or skin break down and other care issues identified by the physician in the initial orders. Your staff needs to be aware of these concerns and act on preventive measures. When you admit a new resident who has fallen at home, you already know the resident is at risk of falling again. You would implement interventions to prevent the resident from falling on the first day of admission. How the facility records the initial care plan in the resident's clinical record is dependent on the policy of the facility.

Q. Does the MDS have to be completed and signed at R2b on the same date recorded at A3a (Assessment Reference date) and transmitted to the state?
A. No, the Assessment Reference Date A3a (Last day of MDS observation period) identifies the end of the assessment period. The date recorded at R2b indicates that the RAI coordinator has determined that the assessment has been completed. The date recorded at R2b must be within 14 days of the admission date. If the facility participates in the Medicaid program, all assessments must be transmitted to the state within 7 days of the date recorded at R2b. Facilities which participate in the Medicare program and do not participate in the Medicaid program must transmit an assessment within 31 days. However, it is strongly recommended that facilities transmit assessments at least once a week.

Use of Antipsychotic Drugs in Nursing Facilities

Since 1990 there has been a significant change in practice related to the use of antipsychotic drugs in older adults who live in nursing facilities. With implementation of the Federal regulations in 1990, the use of antipsychotic drugs has decreased both in the number of residents receiving antipsychotic drugs and the doses administered. The Health Care Financing Administration issued specific procedures which surveyors follow when evaluating the administration of antipsychotic medications to residents of certified nursing facilities. At a recent meeting of providers, it was identified that staff in some nursing facilities are misinformed about the information found in the guidance to surveyors. It is strongly recommended that each certified facility have a current copy of the Federal survey procedure found in the State Operations Manual. Provider organizations can assist individual facilities in obtaining a copy of the July 1999 issuance.

The guidance contains a listing of the daily doses of the most common antipsychotics. There is a statement in the guidance that the doses listed were intended for residents with cognitive disorders including dementia and delirium. The standard of practice for treating older adults with organic mental syndromes is to initiate the drug with a low dose and to gradually increase the dose only if necessary to treat the resident's symptoms. If the physician determines that the dosage necessary to treat the resident is greater than the guidelines, the rationale for that decision should be documented in the resident's clinical record. This regulation was not intended to affect residents who have a major mental illness such as schizophrenia.

All residents who receive an antipsychotic medication must be monitored for side effects. Many facilities use standardized forms to perform this function. A specific form is not required. However, surveyors will review the resident's clinical record to ensure that there is evidence that the staff monitors the resident for side effects. The newer antipsychotics do not appear to have some of the serious side effects as the older drugs. However, all drugs in this classification can cause serious adverse reactions. It is essential that staff be aware of the side effects for each drug administered and the clinical record demonstrates that symptoms of adverse drug reactions are promptly reported to the resident's physician.

42 CFR 483.25(1)(2)(ii) states that residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. On page PP-127 there is a discussion of the circumstances under which a resident would not be required to undergo a gradual dose reduction. This information should be shared with physicians who treat residents with antipsychotic medications.

It is not appropriate to attempt dose reductions for residents who have a major psychiatric illness and whose

behavior has been well managed with an antipsychotic drug unless it is clinically indicated. Sudden dose reductions have resulted in serious exacerbation of a psychiatric illness in some residents. The focus of the regulation is to ensure that residents who receive antipsychotic drugs receive the appropriate dosage, are monitored for side effects and have the doses reduced or the drug discontinued which it is clinically indicated. It is very important that facility staff and the resident's physician work together to ensure that this requirement is met.

Tatyana Gurvich, Phar.D., and Janet A. Cunningham, MD, recently published an article on the subject of antipsychotrophic drugs in nursing homes. This article includes information on the use of the newer antipsychotic drugs. Facility staff can access the article on the Web at www.aafp.org or by requesting the article through their public library.

Gurvich, T. and Cunningham, J. Appropriate Use of Psychotropic Drugs in Nursing Homes. *American Family Physician.* March 1, 2000.

FEMA Releases Design and Construction Guidance for Community Shelters

Tornadoes and hurricanes are among the most destructive forces of nature. More than 1,200 tornadoes are reported nationwide per year. Since 1950, there has been an average of 89 deaths and 1,521 injuries annually, and devastating personal and property losses caused by tornadoes. The most violent tornadoes are capable of tremendous destruction with wind speeds of 250 mph or more.

FEMA's Building Performance Assessment Team investigation of the May 1999 tornadoes in Oklahoma and Kansas made it clear that a severe wind event can cause a large loss of life or a large number of injuries in high-occupancy buildings (e.g., school buildings, hospitals and other critical care facilities, nursing homes, day-care centers, and commercial buildings). The teams report is available at <http://www.fema.gov/mit/bpat>, or may be ordered from FEMA publications. The report is **FEMA 342, Midwest Tornadoes of May 3, 1999**.

FEMA 361, Design and Construction Guidance for Community Shelters, is a design manual for engineers, architects, building officials, and shelter owners that provides guidance on the design and construction of tornado community shelter. For the purpose of this guidance, a community shelter is defined as a shelter that is designed and constructed to protect a large number of people from a natural hazard event. The number of persons taking refuge in the shelter could be up to several hundred or more.

The manual provides detailed guidance concerning the design and construction of shelters for extreme wind events - guidance that is currently not available in building codes or standards, or in other design guides. The shelter designs are intended to provide ***near-absolute protection*** from extreme wind events. FEMA 361 replaces the **National Performance Criteria for Tornado Shelters.** An updated version of the performance criteria will apply to commercially available shelters intended for residential applications.

Shelter location, design loads, performance criteria, and human factor criteria that should be considered for the design and construction of such shelters is discussed. In addition to design guidance, the manual will include: decision-making software; checklists for evaluating existing buildings; real-life case studies, and sample plans for designs created using the guidance in this manual. The case studies include construction drawings, emergency operation plans, and cost estimates for designs created using the guidance in the manual.

For more information on FEMA's safe room initiative, visit the safe room web site at <http://www.fema.gov/mit/saferoom/>. Copies of the manual, **FEMA 361**, **Design and Construction Guidance for Community Shelters,** are free and can be ordered from FEMA Publications by calling 1-800-480-2520. FEMA 361 will also be available from the web site in a couple of weeks.

Credentialing Update

CMA Curriculum and Test Development

The CMA curriculum development committee met July 14, 2000 to begin the process of drafting a new curriculum. The committee will also review current regulations and practices for certified medication aides and suggest changes. If you have comments about the regulations and/or practices, please submit them to Martha Ryan, 900 S.W. Jackson, Suite 1051S, Topeka, Kansas 66612 or mryan@kdhe.state.ks.us.

The curriculum development committee consists of: Caprice Becker, R.N., Kansas Health Occupations Advisory Committee; Joyce Bedsworth, R.N., M.N., Kansas Association of Homes and Services for the Aging; Charlotte Campbell, R.N., Kansas Health Occupations Advisory Committee; Beatrice Carney, R.N., M.N., Kansas Health Occupations Advisory Committee; Mary Gedrose, R.N., Kansas Health Occupations Advisory Committee; Carly Haynes, R.P.H., Kansas State Board of Pharmacy; Linda Runge, R.N., Kansas Professional Nursing Home Administrators Association; and Anne Schmidt, R.N., B.A., Kansas Health Occupations Advisory Committee.

The test development committee is scheduled to meet September 26, 2000. The committee consists of: Deb Bader, R.N., Kansas Health Care Association; Kathy Bode, R.N., M.S., Kansas Health Occupations Advisory Group; Kathy Cureton, R.N., Kansas Health Occupations Advisory Group; Denise German, R.N., L.N.H.A., Kansas Advocates for Better Care; Kathleen Lee, C.M.A., Kansas Health Care Association; Carolyn Middendorf, R.N., A.R.N.P., M.N., Kansas Advocates for Better Care and Kansas State Nurses Association; Linda Pfeffer, R.N., B.S.N., M.S., self nominated; Kristine Pfeifer, R.N., Kansas Health Occupations Advisory Group; and Terri Stewart, R.N./c, Kansas Health Occupations Advisory Group.

Adult Care Home Administrators

The revised Adult Care Home Administrator licensing regulations were adopted by the Kansas Board of Adult Care Home Administrators and were effective as of July 14, 2000. Copies of the regulations may be obtained either through industry associations, by contacting Health Occupations Credentialing (785-296-0056) or by logging onto the KDHE Internet site at: www.kdhe.state.ks.us/hoc.

During the state fiscal year 2000, there were 60 initial administrator licenses issued, 12 reinstatements, 285 renewals, 19 temporary and 21 reciprocal licenses issued. The Board is considering options to modify the Administrator in training program and the temporary license requirements. If you have any suggestions or comments about these two sections of regulation, please forward them to a board member or the Health Occupations Credentialing section at 900 SW Jackson, Suite 1051 S, Topeka, KS, 66612-1290 (email lroberts@kdhe.state.ks.us).

During the same time period, there were 4,467 initial nurse aide certificates issued, 561 certified from another state, and 125 certified via the allied health training option.

Certification No Longer Required for AD/SSD Course

Activity directors and social service designees who meet the qualifications for these positions by taking the KDHE approved courses for SSD's and AD's are no longer required to be nurse aides. The change was effective in October of 1999.

Criminal Background Checks

The Criminal Background Check Program anticipates issuing weekly notices to adult care homes and home health agencies beginning in October. These notices will identify individuals the employer has submitted a request, and no criminal history information was received from the KBI. This service will provide confirmation of all persons submitted for a background check.

A proposal has been submitted to the department's Information Systems to explore the feasibility of automating the Kansas Nurse Aide Registry. Some of the objectives of this proposal are:

- Allowing multiple calls to be answered and routed appropriately.
  Support electronic transmission of documents.
- Access 24 hours a day, seven days a week.
- Collect employment information directly from employers (adult care homes, home health agencies, employment agencies)

Below is statistical information from fiscal year 2000 (July 1, 1999-June 30, 2000).

• Criminal Background Check Requests Processed	24,676
• Number of Individuals with Criminal History Information	5,944
• Number of Notices of Employment Prohibitions Issued	185
• Number of Individuals Prohibited	165

ANE ISSUE STATISTICS 6/1/00 to 8/31/00
Complaint Calls Assigned for Investigation

ANE Investigations		Care Issues Investigated	
Total	488	Total	435
Jun	153	June	148
July	149	July	127
Aug	186	Aug	160

*Licensure Category	Correction Orders 2000 Quarters			
	1st	2nd	3rd	4th
Inadequate or inappropriate hygiene and skin care	2	6		
Inadequate or unqualified staffing	4	1		
Inoperable or inaccessible call system	0	0		
Inappropriate or unauthorized use of restraints	0	2		
Unsafe medication administration or storage	2	9		
Inadequate nursing services other skin care	2	1		
Inadequate or inappropriate asepsis technique	0	0		
Inadequate or inappropriate dietary/nutritional services	6	1		
Unsafe storage or hazardous or toxic substances	1	0		
Failure to maintain equipment	0	0		
Resident right violations	7	5		
Unsafe high water temperature	0	0		
Inadequate hot water	0	0		
General sanitation and safety	3	1		
Other (including inappropriate admission)	1	14		
Inadequate rehabilitation services	1	0		
Civil Penalties	0	1		
Correction Orders	11	17		
Bans on Admission	4	10		

*A correction order or civil penalty may consist of multiple issues summarized within the licensure categories above.

FEDERAL REMEDIES -CATEGORIES 2 & 3 - 2000 Quarters

	1st	2nd	3rd	4th
Civil Monetary Penalties Recommended	18	3		
Denial of Payment for New Admissions Imposed	27	21		
Terminations	0	0		

REQUEST FOR BED CHANGE

Facility _____ Fed Provider # _____
Address _____ State ID # _____
City _____ Zip _____ Phone (____)_____

I. Check box(s) that best describe requested action:

- ❒ This is an *increase* of **Medicare Certified beds** from _____ to _____ , or
- ❒ This is an *decrease* of **Medicare Certified beds** from _____ to _____ ,
- ❒ This is a *change* in location of **Medicare Certified beds** (Attached is a separate sheet that describes change)

and/or

- ❒ This is a request to *increase* **the licensed bed capacity** from _____ to _____ , or
- ❒ This is a request to *decrease* **the licensed bed capacity** _____ to _____.

II. Indicate facility type or section of facility in which the change is being requested:

- ❒ Nursing facility
- ❒ Residential Health Care Facility
- ❒ Adult Day Care
- ❒ Assisted Living Facility
- ❒ Home Plus
- ❒ Boarding Care ❒ ICF/MR

III. Indicate **Medicare** cost reporting month:_____ and/or **Medicaid** cost reporting month: _____ (as appropriate).

- ❒ Not applicable since this is a licensed category that has no cost report year.

IV. Changes in Medicare & Medicaid certified beds only will require the facility to submit floor plans identifying all areas of the facility with current certified bed configuration and the proposed certified bed configuration. You will need to identify the room number(s) and the number of beds for each room.

V. Indicate Intermediary (for Medicare participating facilities only):

- ❒ Blue Cross of Kansas
- ❒ Mutual of Omaha
- ❒ Other _____

VI. If the change request indicated in Section I affects a change in the number of licensed beds, there will be a charge of $50 plus $15 per resident for each bed increase or decrease (KAR 28-39-145a (j). Indicate amount enclosed: $_____.

Submitted by:_____ Date:_____
(Name and Title)

Submit form to: Licensure/Certification Program, Bureau of Health Facilities
900SW Jackson, Room 1001, Topeka KS 66612-1220

TO BE COMPLETED BY LICENSURE/CERTIFICATION STAFF

❒ _____ ~~(Licensure Approval)~~ ~~(Date)~~
(Certification Approval)

❒ _____ ~~(Licensure Dis-Approval)~~ _____
(Certification Dis-Approval) (Date)

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